COMPARISON OF BENEFITS*
FOR CITY OF EUGENE
EPEA-REPRESENTED EMPLOYEES

Effective July 1, 2012

Medical/Vision/Pharmacy coverage is administered by PacificSource Health Plans
Dental coverage is administered by Oregon Dental Service (ODS)
City of Eugene Employee Benefits Website: www.eugene-or.gov/employeebenefits

EPEA-Represented BENEFITS	City Health Plan (PPO) In-Network Benefit	City Managed Care Plan (POS) PCP/Referred In-Network Benefit
Note: Benefits described below for the health plan options assume plan members receive in-network services preauthorized by their City Managed Care Plan (POS) PCP or through the City Health Plan PPO.		
General Information		
Payroll Deduction	EPEA-Represented full-time employees: Individual $20.00 per month Two-Party $50.00 per month Family $65.00 per month Employees may Opt-Out of health insurance with proof of other coverage.	EPEA-Represented full-time employees: Individual $20.00 per month Two-Party $50.00 per month Family $65.00 per month Employees may Opt-Out of health insurance with proof of other coverage.
Eligible Dependents	Spouse or domestic partner and dependent children. In addition to other policy requirements, eligible children up to age 26 can be covered as long as they are not eligible to enroll in another employer-sponsored health plan, other than a group health plan of a parent.	
Benefit Levels	Preferred Provider Organization (PPO) plan, using the PacificSource Preferred PSN PPO network. Most benefit levels after the deductible: ▪ In-Network provider: 80% of discounted rates; ▪ Non-Network provider: 50% of reasonable and customary charges.	Point of Service (POS) plan, using the PacificSource Prime PSN network. It is necessary for you and your covered dependents to choose a Primary Care Practitioner (PCP). Benefits are paid at the highest level when provided or referred by your PCP. Most Non-Network/Non-Referred provider benefits are 50% of reasonable and customary charges after co-pay.
PacificSource Service Area	Worldwide for emergencies. Service area for the PacificSource Preferred PSN and Prime PSN Networks includes all Oregon and Idaho counties. Also Pacific, Wahkiakum, Cowlitz, Clark, Skamania and Klickitat counties in Washington state. Members living outside the PacificSource network can receive in-network cost savings through the Idaho Physician's Network, the Montana InterWest Health Network or the First Health Network. See Handbook for details.	
Choice of Physician	Any qualified physician. While in the service area, you must use a network provider or hospital to receive in-network benefits.	It is necessary for you and your covered dependents to choose a Primary Care Physician (PCP). For most services, you must use or be referred by your PCP to be paid at the highest benefit level. See Benefit Handbook for exceptions.
Calendar Year Medical and Dental Deductibles	Medical: $100 per person; $300 maximum per family. Dental: $25 per person; $75 maximum per family. All benefits paid after the deductible is met unless otherwise noted.	Medical: No deductible for medical coverage. Dental: $25 per person; $75 maximum per family. All benefits paid after the deductible is met unless otherwise noted.

EPEA-Represented BENEFITS	City Health Plan (PPO) In-Network Benefit	City Managed Care Plan (POS) PCP/Referred In-Network Benefit
Out-of Pocket Medical Maximum	$750 per person each calendar year, in addition to the deductible for covered services. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year for covered expenses. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.
Out-of Pocket Rx Maximum	Combined Rx and Medical Maximum (see above). Mail-order not included in out-of-pocket maximum.	$1,350 per person each calendar year. Mail-order not included in out-of-pocket maximum.
Annual Dental Benefit Maximums	First calendar year of coverage: $250*. Each succeeding calendar year: $1,250*. *Does not apply to essential dental benefits for members under age 16. See the Employee Benefits Handbook for details.	
Pre-existing Conditions (Does not apply to members under age 19 or for pregnancy related conditions)		
Open enrollment	If you have been enrolled for 6 consecutive months in one of the City's health plans, you may transfer at open enrollment without any pre-existing condition limitations.	
New Eligible Employees & Dependents	For members age 19 and older, benefits are limited to $2,000 during the first 6 months for illness or injuries for which you received treatment in the 90 days before coverage began. The exclusion period will be reduced by creditable coverage under another health plan.	No pre-existing condition limitations under the City Managed Care Plan.
Claims Filing	Claim forms may be submitted by either the patient or the provider.	No claim forms needed for the City Managed Care Plan.
For more information contact	PacificSource Health Plans – 541.225.2650 or 888.532.5332 (medical/vision/pharmacy) Oregon Dental Service- Portland Office: 888.217.2365 (dental) Risk Services Employee Benefits Program: 541.682.8868	
This comparison of benefits summarizes the general benefits under each plan. It does not provide a full description of benefits. For further information please contact PacificSource for your medical, pharmacy or vision benefits, or ODS for your dental benefits.		
Medical, Vision and Pharmacy Benefits – Administered by PacificSource Health Plans		
Physician Services		
Surgery/Delivery		
Inpatient	80% after deductible.	Covered in full.
Outpatient	100% no deductible.	Surgery covered in full. $10 office visit co-payment if performed in physician's office.
Office Visits	80% after deductible; 80% no deductible for treatment of accidental injury.	Covered in full after $10 co-payment per visit.
Hospital Visits	80% after deductible.	Covered in full.
Allergy Injections	80% after deductible.	Covered in full.
Hospital Services		
Semi-private Room and Board	80% after deductible. *Subject to compliance with utilization review.*	Paid in full after $50 co-payment per day ($250 maximum per stay).

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Emergency Care		
Within Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$50 co-payment per visit; waived if admitted.
Outside of Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$50 co-payment per visit; waived if admitted.
Emergency Transportation	80% after deductible.	$50 per trip; waived if admitted. Air ambulance covered when preauthorized.
Outpatient Services		
CT Scans and MRI	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	Covered in full.
X-Ray, Lab Tests and Radiation Therapy	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	Covered in full.
Rehabilitation (Physical Therapy)	80% after deductible if prescribed by physician.	Covered in full after $10 co-pay per session; limited to 30 sessions/year, (combined with Occupational & Speech Therapy). Must be preauthorized.
Occupational and Speech Therapy	80% after deductible for certain medical conditions if prescribed by physician.	Covered in full after $10 co-pay per session; limited to 30 sessions/year, (combined with Physical Therapy). Must be preauthorized.
Maternity Care		
Hospital Services including Caesarean Sections and Newborn Care	Covered the same as any other medical condition; routine hospital nursery care covered from date of birth; 100% after deductible for delivery at licensed birthing center	Covered in full for outpatient delivery. Inpatient delivery covered in full after $50 co-payment per day ($250 maximum per stay).
Physician Hospital Services including Prenatal, Delivery and Postnatal Care of Mother and Child	80% after deductible.	Covered in full after $25 co-payment per pregnancy.
Preventive and Well-Care Services		
Periodic Physical Exams	Covered at 80% to a maximum benefit of $250; no deductible.	Covered in full after $10 co-payment per visit.
Well-Baby/Child Care	Covered at 80% during first 24 months; no deductible.	Covered in full after $10 co-payment per visit (subject to schedule).
Immunizations	Covered at 80% for adults and children; no deductible. Children under age 2 covered under Well-baby/Child Care.	Covered in full.
Cancer Screenings and Gynecological Exams: including Colonoscopy, Mammography, Breast, Pap and Pelvic Exams	Covered at 80%; no deductible. Subject to schedule of eligibility	Covered in full after $10 co-pay. Subject to schedule of eligibility.

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Other Medical Treatment		
Alternate Care	▪ Acupuncture: 80% after deductible. ▪ Chiropractor: 80% after deductible, limited to 52 visits a calendar year. ▪ Office visits to Licensed Naturopaths ($300 benefit max), Licensed Massage Therapists ($300 benefit max), and Registered Dietitians ($200 benefit max): 80% after deductible. Benefit maximums per calendar year as noted. No limitation on number of medically necessary visits.	Services of Licensed Chiropractors, Licensed Massage Therapists, Registered Acupuncturists and Registered Dieticians; and office visits to Licensed Naturopaths: $10 co-pay per visit, up to 12 visits (12 total visits combined for all types of alternate care providers) per calendar year.
Durable Medical Equipment	Rental covered at 80% after deductible when prescribed by a physician (up to the purchase price of rental).	Covered at 80%.
Hearing Aids	Adults: 50% of eligible expenses covered after deductible, up to a $500 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses after deductible, up to a $4000 maximum during a 48-month period. Maximum adjusted January 1 of each year.	Adults: 50% of eligible expenses covered up to a $500 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses with no copay, up to a $4000 maximum during a 48-month period. Maximum adjusted January 1 of each year.
Hearing Analysis	Covered at 80% after deductible if prescribed by a physician when medically necessary.	Routine hearing exams covered in full after $10 co-payment for children under age 18 once every 24 months when performed by PCP.
Home Health Care	Covered in full after deductible when provided by RN or registered physical therapist and prescribed by a physician.	Covered in full when preauthorized.
Hospice Care	Covered in full after deductible.	Covered in full when preauthorized. ($15,000 lifetime maximum)
Mental Health & Chemical Dependency Services, including Alcoholism	Covered the same as any other medical condition, and may be subject to deductible, coinsurance or copay and limitations. See specific service type (for example, hospital or physician services) for coverage levels. Benefits provided in accordance with state and federal requirements.	
Podiatrist	80% after deductible.	Covered in full after $10 co-pay for non-routine foot care when preauthorized by a PCP.
Prosthetic Devices (Pacemaker, artificial limb, etc.)	80% after deductible for devices replacing body functions.	80% for initial device replacing body function when obtained while you are covered by this Plan and when need first arises.
Tobacco Cessation Treatment	Eligible expenses covered up to a $500 lifetime maximum benefit for members age 15 or older participating in a tobacco cessation program, and up to two quit attempts through the Quit For Life tobacco cessation program. No deductible required.	

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Pharmacy		
Prescription Drugs	Retail – Deductible applies. Pay discounted price in full at pharmacy, and then submit claim form for reimbursement. Generic: $10 co-payment Others: 20% co-payment	Retail (No claim form required): Generic: 50% co-pay or $10* Preferred: 50% co-pay or $25* Non- Preferred: 50% co-pay or $40* *whichever is greater
	Mail Order (Caremark or Wellpartner) -No deductible; no claim form required: Generic: $10 co-payment Preferred: $20 co-payment Non-Preferred: $25 co-payment or 25%, whichever is greater (with $50 cap)	Mail-order (Caremark or Wellpartner): Up to 90 day supply: Generic: $15 co-pay Preferred: $25 co-pay Non-Preferred: $50 co-pay
Vision		
Eye Exams	80% with no deductible up to $75 once every 12 months.	Covered in full after $10 co-payment for children under age 18 once every 24 months. Adults covered at 80% with no deductible up to $75 once every 12 months.
Prescription Lenses	Lenses and frames **or** cosmetic contacts covered once every 24 months. Frames $60 Single lens $25 per lens Bifocals $40 per lens Cosmetic Contacts $90 (both lenses) $75 per lens for contacts required after cataract surgery or if vision cannot be corrected to 20/70 without such lenses. Covered once every 24 months.	
Dental* - Administered by Oregon Dental Service (ODS) *The City's dental plan utilizes participating dentists who have contracts with ODS. Benefit levels for non-participating dental providers are based on the prevailing fee level for covered services.		
ODS Service Area	The ODS Delta Dental Premier Network includes all counties in Oregon. Members living outside of Oregon can receive in-network benefits through ODS' national affiliation with Delta Dental Plans Association.	
Dental Deductible	$25 per person; $75 maximum per family. All benefits paid after the deductible is met unless otherwise noted.	
Maximums	First calendar year of coverage: $250*. Each succeeding calendar year: $1,250*. *Does not apply to essential dental benefits for members under age 16. See the Employee Benefits Handbook for details.	
Preventive Dental Care: Exams, Fluoride Bite-Wing X-Rays, and Routine Cleaning	100% no deductible.	
Fillings, Restorative Crowns, Denture Repairs	80% after $25 deductible.	
Initial and Replacement Dentures and Bridgework	50% after $25 deductible. Covered only if previous denture or bridgework is more than five years old, and teeth were removed while the covered person was eligible for coverage under this plan.	
Orthodontia	50% with no deductible. $2,000 lifetime maximum per covered person.	